FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

I. IDPH Facility ID Number: 0047522

Facility Name: Timbercreek Rehabilitation & Health Care Center

Address: 2220 State Street (Number) Pekin (City) 61554 (Zip Code)

County: Tazewell

Telephone Number: 309-347-1110 **Fax #** 309-347-1043

HFS ID Number: 20-3224201005

Date of Initial License for Current Owners: 10/1/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** 312-634-4581
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) McGladrey & Pullen, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	202	Skilled (SNF)	202	73,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	202	TOTALS	202	73,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,946	7,010	6,230	46,186	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,946	7,010	6,230	46,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.64%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 202 and days of care provided 6,230

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care C # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	202,816	29,140		231,956		231,956	4,590	236,546			1
2	Food Purchase		215,503		215,503		215,503	(10,668)	204,835			2
3	Housekeeping	135,901	15,539		151,440		151,440	148	151,588			3
4	Laundry	47,363	19,628		66,991		66,991		66,991			4
5	Heat and Other Utilities			94,130	94,130		94,130	609	94,739			5
6	Maintenance	47,461	62,416	41,388	151,265		151,265	11,377	162,642			6
7	Other (specify):* Home Office Benefits							2,858	2,858			7
8	TOTAL General Services	433,541	342,226	135,518	911,285		911,285	8,914	920,199			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	1,705,462	321,936	49,211	2,076,609		2,076,609	14,174	2,090,783			10
10a	Therapy		240	593,960	594,200		594,200	1,090	595,290			10a
11	Activities	58,648	4,750	673	64,071		64,071		64,071			11
12	Social Services	47,982	381		48,363		48,363		48,363			12
13	CNA Training											13
14	Program Transportation			3,657	3,657		3,657		3,657			14
15	Other (specify):* Home Office Benefits							4,459	4,459			15
16	TOTAL Health Care and Programs	1,812,092	327,307	655,001	2,794,400		2,794,400	19,723	2,814,123			16
	C. General Administration											
17	Administrative	92,977		122,500	215,477		215,477	(87,390)	128,087			17
18	Directors Fees											18
19	Professional Services			4,225	4,225		4,225	20,113	24,338			19
20	Dues, Fees, Subscriptions & Promotions			14,413	14,413		14,413	916	15,329			20
21	Clerical & General Office Expenses	38,375	6,789	68,899	114,063		114,063	62,964	177,027			21
22	Employee Benefits & Payroll Taxes			391,745	391,745		391,745	3,905	395,650			22
23	Inservice Training & Education			483	483		483	422	905			23
24	Travel and Seminar			890	890		890	1,695	2,585			24
25	Other Admin. Staff Transportation			9,845	9,845		9,845	4,916	14,761			25
26	Insurance-Prop.Liab.Malpractice			38,845	38,845		38,845	2,604	41,449			26
27	Other (specify):* Home Office Benefits							12,705	12,705			27
28	TOTAL General Administration	131,352	6,789	651,845	789,986		789,986	22,850	812,836			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,376,985	676,322	1,442,364	4,495,671		4,495,671	51,487	4,547,158			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center #0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			278,388	278,388		278,388	16,302	294,690			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			485,599	485,599		485,599	38,858	524,457			32
33	Real Estate Taxes			80,400	80,400		80,400	4,562	84,962			33
34	Rent-Facility & Grounds							2,078	2,078			34
35	Rent-Equipment & Vehicles			30,784	30,784		30,784	1,358	32,142			35
36	Other (specify):*											36
37	TOTAL Ownership			875,171	875,171		875,171	63,158	938,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,955	1,364	9,319		9,319		9,319			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,595	110,595		110,595		110,595			42
43	Other (specify):* Nonallowable Cost			213,129	213,129		213,129	(213,129)				43
44	TOTAL Special Cost Centers		7,955	325,088	333,043		333,043	(213,129)	119,914			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,376,985	684,277	2,642,623	5,703,885		5,703,885	(98,484)	5,605,401			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,880)	2		4
5	Telephone, TV & Radio in Resident Rooms	(545)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	921	30		9
10	Interest and Other Investment Income	(8,575)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(558)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,600)	43		18
19	Entertainment				19
20	Contributions	(130)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,027)	43		24
25	Fund Raising, Advertising and Promotional	(9,891)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(86,487)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (243,772)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	145,288		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 145,288		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (98,484)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Timbercreek Rehabilitation & Health Care Center

ID# 0047522

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable Marketing Events	$ (8,488)	43	1
2	Labs - Part A	(11,391)	43	2
3	X-Rays - Part A	(10,254)	43	3
4	Offset Vending Machine Revenue	(3,054)	2	4
5	Salaries-Marketing/Other	(35,343)	43	5
6	Marketing Supplies	(1,901)	43	6
7	Offset Transportation Revenue	(66)	25	7
8	Nonallowable travel	(12,157)	24	8
9	Offset Miscellaneous Revenue	(2,487)	21	9
10	Nonallowable Dues	(1,346)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(86,487)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center **#** 0047522 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	3,285	0	1,305	0	0	0	0	0	0	0	4,590	1
2	Food Purchase	(6,934)	161	0	10	0	0	0	0	0	0	0	(6,763)	2
3	Housekeeping	0	145	0	3	0	0	0	0	0	0	0	148	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	609	0	0	0	0	0	0	0	0	0	609	5
6	Maintenance	0	8,352	0	3,025	0	0	0	0	0	0	0	11,377	6
7	Other (specify):*	0	1,316	0	1,542	0	0	0	0	0	0	0	2,858	7
8	**TOTAL General Services**	(6,934)	13,868	0	5,885	0	0	0	0	0	0	0	12,819	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	11,874	0	2,300	0	0	0	0	0	0	0	14,174	10
10a	Therapy	0	1,090	0	0	0	0	0	0	0	0	0	1,090	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	3,671	0	788	0	0	0	0	0	0	0	4,459	15
16	**TOTAL Health Care and Programs**	0	16,635	0	3,088	0	0	0	0	0	0	0	19,723	16
	C. General Administration													
17	Administrative	0	(90,132)	0	2,742	0	0	0	0	0	0	0	(87,390)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,176	0	5,937	0	0	0	0	0	0	0	20,113	19
20	Fees, Subscriptions & Promotions	(1,346)	1,389	0	873	0	0	0	0	0	0	0	916	20
21	Clerical & General Office Expenses	(2,487)	0	52,179	13,272	0	0	0	0	0	0	0	62,964	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	422	0	0	0	0	0	0	0	0	422	23
24	Travel and Seminar	(12,157)	0	12,634	1,218	0	0	0	0	0	0	0	1,695	24
25	Other Admin. Staff Transportation	(66)	0	3,361	1,620	0	0	0	0	0	0	0	4,915	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,487	117	0	0	0	0	0	0	0	2,604	26
27	Other (specify):*	0	0	9,221	3,484	0	0	0	0	0	0	0	12,705	27
28	**TOTAL General Administration**	(16,056)	(74,567)	80,304	29,263	0	0	0	0	0	0	0	18,944	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,990)	(44,064)	80,304	38,236	0	0	0	0	0	0	0	51,486	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	921	0	12,865	2,516	0	0	0	0	0	0	0	16,302	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,575)	0	7,146	40,287	0	0	0	0	0	0	0	38,858	32
33	Real Estate Taxes	0	0	1,508	3,054	0	0	0	0	0	0	0	4,562	33
34	Rent-Facility & Grounds	0	0	1,462	616	0	0	0	0	0	0	0	2,078	34
35	Rent-Equipment & Vehicles	0	0	766	592	0	0	0	0	0	0	0	1,358	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,654)	0	23,747	47,065	0	0	0	0	0	0	0	63,158	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(213,128)	0	0	0	0	0	0	0	0	0	0	(213,128)	43
44	**TOTAL Special Cost Centers**	(213,128)	0	0	0	0	0	0	0	0	0	0	(213,128)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(243,772)	(44,064)	104,051	85,301	0	0	0	0	0	0	0	(98,484)	45

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 3,285	$ 3,285	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	161	161	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	145	145	3
4	V								4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	609	609	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	8,352	8,352	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,316	1,316	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	11,874	11,874	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	1,090	1,090	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,671	3,671	10
11	V	17	Administrative	122,500	Petersen Health Care, Inc.	100.00%	32,368	(90,132)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	14,176	14,176	12
13	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	1,389	1,389	13
14	Total			$ 122,500			$ 78,436	$ * (44,064)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 52,179	$ 52,179	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	422	422	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	12,634	12,634	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,361	3,361	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	2,487	2,487	19
20	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,221	9,221	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	12,865	12,865	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,146	7,146	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,508	1,508	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,462	1,462	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	766	766	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 104,051	$ * 104,051	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 1,305	$ 1,305	15
16	V	2	Food		Petersen Health Care, Inc.	100.00%	10	10	16
17	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	3	3	17
18	V								18
19	V								19
20	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,025	3,025	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,542	1,542	21
22	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,300	2,300	22
23	V								23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	788	788	24
25	V	17	Administrative		Petersen Health Care, Inc.	100.00%	2,742	2,742	25
26	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,937	5,937	26
27	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	873	873	27
28	V	21	Clerical & General Office		Petersen Health Care, Inc.	100.00%	13,272	13,272	28
29	V								29
30	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,218	1,218	30
31	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,620	1,620	31
32	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	117	117	32
33	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,484	3,484	33
34	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,516	2,516	34
35	V	32	Interest		Petersen Health Care, Inc.	100.00%	40,287	40,287	35
36	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	3,054	3,054	36
37	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	616	616	37
38	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	592	592	38
39	Total			$			$ 85,301	$ * 85,301	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care (# 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2.02	4.05	Salary	$ 32,368	17,7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 32,368		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,141,512	56	$ 81,179	$ 80,967	46,186	$ 3,285	1
2	2	Food	Patient Days	1,141,512	56	3,989		46,186	161	2
3	3	Housekeeping	Patient Days	1,141,512	56	3,589		46,186	145	3
4										4
5	5	Utilities	Patient Days	1,141,512	56	15,054		46,186	609	5
6	6	Maintenance	Patient Days	1,141,512	56	206,416	110,513	46,186	8,352	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,512	56	32,526		46,186	1,316	7
8	10	Nursing and Medical Records	Patient Days	1,141,512	56	293,462	289,197	46,186	11,874	8
9	10A	Therapy	Patient Days	1,141,512	56	26,945		46,186	1,090	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,512	56	90,724		46,186	3,671	10
11	17	Administrative	Patient Days	1,141,512	56	800,000	800,000	46,186	32,368	11
12	19	Professional Services	Patient Days	1,141,512	56	350,361	4,303	46,186	14,176	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,512	56	34,325		46,186	1,389	13
14	21	Clerical & General Office	Patient Days	1,141,512	56	1,289,623	954,322	46,186	52,179	14
15	23	Inservice Training & Education	Patient Days	1,141,512	56	10,426		46,186	422	15
16	24	Travel and Seminar	Patient Days	1,141,512	56	312,259		46,186	12,634	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,512	56	83,062		46,186	3,361	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,512	56	61,457		46,186	2,487	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,512	56	227,912		46,186	9,221	19
20	30	Depreciation	Patient Days	1,141,512	56	317,964		46,186	12,865	20
21	32	Interest	Patient Days	1,141,512	56	176,614		46,186	7,146	21
22	33	Real Estate Taxes	Patient Days	1,141,512	56	37,282		46,186	1,508	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,512	56	36,133		46,186	1,462	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,512	56	18,933		46,186	766	24
25	TOTALS					$ 4,510,235	$ 2,239,302		$ 182,487	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	427,669	46	$ 12,081	$ 11,958	46,186	$ 1,305	1
2	2	Food	Patient Days	427,669	46	93		46,186	10	2
3	3	Housekeeping	Patient Days	427,669	46	28		46,186	3	3
4										4
5										5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	46,186	3,025	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		46,186	1,542	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	46,186	2,300	8
9										9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		46,186	788	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	46,186	2,742	11
12	19	Professional Services	Patient Days	427,669	46	54,971		46,186	5,937	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		46,186	873	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	46,186	13,272	14
15										15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280		46,186	1,218	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		46,186	1,620	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		46,186	117	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265		46,186	3,484	19
20	30	Depreciation	Patient Days	427,669	46	23,301		46,186	2,516	20
21	32	Interest	Patient Days	427,669	46	373,049		46,186	40,287	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282		46,186	3,054	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		46,186	616	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		46,186	592	24
25	TOTALS					$ 789,885	$ 150,702		$ 85,301	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care C # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	$ 4,210,000	$ 4,148,545	09/20/10	Varies	$ 357,953	1
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	820,000	818,500	09/20/10	0.1000	127,646	2
3												3
4							Allocation from Home Office				47,433	4
5							Offset Interest Income				(8,575)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,030,000	$ 4,967,045			$ 524,457	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,030,000	$ 4,967,045			$ 524,457	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center **#** 0047522 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		$ 80,316	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2005	$ 80,316	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 80,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **2006 Home Office Allocation**		4,562	
TOTAL REFUND $ **For** **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 84,962	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2001		8
2002		9
2003		10
2004		11
2005	80,316	12

Tax accrual based on prior year tax bill

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Timbercreek Rehabilitation & Health Care Center COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047522

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309-691-8113) FAX #: 309-691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-04-36-412-004	Nursing Home	$ 80,316.00	$ 80,316.00
2.		2006 Home Office Allocation	$	$ 4,562.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 80,316.00	$ 84,878.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,020 B. General Construction Type: Exterior Brick Frame Metal Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	334,995	2005	$ 220,500	1
2					2
3	TOTALS	334,995		$ 220,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	202		2005	1974	$ 4,040,000	$	25	$ 161,600	$ 161,600	$ 242,400	4
5											5
6	Home Office Allocation			2006	27,546			1,205	1,205	1,205	6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	1,500	9
10	Nurses Station			2006	33,290		25	666	666	666	10
11	J.C. Painting			2006	10,951		5	1,095	1,095	1,095	11
12	G-M Mechanical of Canton, Inc			2006	4,998		15	167	167	167	12
13											13
14											14
15											15
16											16
17	Land Impovement Booked					1,000			(1,000)		17
18	Building Booked					161,699			(161,699)		18
19	Building Improvement Booked					832			(832)		19
20											20
21											21
22	Home Office Allocation			2006	1,637			151	151	151	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,133,422	$ 163,531		$ 165,884	$ 2,353	$ 247,184	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 779,782	$ 114,857	$ 114,543	$ (314)		$ 171,813	71
72	Current Year Purchases	4,240		238	238		238	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			14,025	14,025			74
75	TOTALS	$ 784,022	$ 114,857	$ 128,806	$ 13,949		$ 172,051	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,137,944	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 278,388	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 294,690	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,302	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 419,235	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ N/A	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Home Office Allocation				2,078			5
6								6
7	TOTAL				$ 2,078 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

N/A

9. Option to Buy: ☐ YES ☒ X NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 32,142 Description: Dish Machine 748; Copy Machine 4,033; Nsg Equip 26,003; Home Office 1,358
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A,3	hrs	$	2,791	$ 224,134	$	2,791	$ 224,134	1
2	Licensed Speech and Language Development Therapist	10A,3	hrs		651	62,970		651	62,970	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A,3 & 2	hrs		3,944	306,511	240	3,944	306,751	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				578		578	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39,3			17	1,364		17	1,364	12
13	Other (specify): Resp. Therapy/Oxygen	10A,3	hrs		5	345	7,377	5	7,722	13
14	TOTAL			$	7,408	$ 595,324	$ 8,195	7,408	$ 603,519	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center **#** 0047522 **Report Period Beginning:** 01/01/2006 **Ending:** 12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2006 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 575,471	$ 575,471	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,358,838	1,358,838	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,053	17,053	7
8	Accounts Receivable (owners or related parties)	11,601	11,601	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,962,963	$ 1,962,963	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,308,790	4,353,922	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	784,022	784,022	16
17	Accumulated Depreciation (book methods)	(338,237)	(419,235)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security Deposit	2,909	2,909	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,757,484	$ 4,721,618	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,720,447	$ 6,684,581	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 793,651	$ 793,651	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,909	45,909	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,169	21,169	31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,400	80,400	32
33	Accrued Interest Payable	51,830	51,830	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	28,844	28,844	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,021,803	$ 1,021,803	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	818,500	818,500	40
41	Bonds Payable	4,148,545	4,148,545	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,967,045	$ 4,967,045	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,988,848	$ 5,988,848	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 731,599	$ 695,733	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,720,447	$ 6,684,581	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):	150,616	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 150,616	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	580,986	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(3)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 580,983	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 731,599	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,871,595	1
2	Discounts and Allowances for all Levels	83,832	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,955,427	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	931,684	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 931,684	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	113,665	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,880	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	233,674	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	32,409	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 383,628	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,575	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,575	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	2,503	28
28a	Vending	3,054	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,557	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,284,871	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	911,285	31
32	Health Care	2,794,400	32
33	General Administration	789,986	33
	B. Capital Expense		
34	Ownership	875,171	34
	C. Ancillary Expense		
35	Special Cost Centers	222,448	35
36	Provider Participation Fee	110,595	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,703,885	40
41	**Income before Income Taxes (line 30 minus line 40)****	580,986	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 580,986	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 66,491	$ 31.97	1
2	Assistant Director of Nursing	1,970	1,970	50,882	25.82	2
3	Registered Nurses	4,121	4,121	106,925	25.95	3
4	Licensed Practical Nurses	26,149	26,530	522,558	19.70	4
5	CNAs & Orderlies	84,918	85,270	847,349	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,269	2,274	31,910	14.04	9
10	Activity Assistants	2,685	2,757	26,738	9.70	10
11	Social Service Workers	4,109	4,117	47,982	11.65	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	58,020	27.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,062	20,121	144,796	7.20	15
16	Dishwashers					16
17	Maintenance Workers	4,475	4,475	47,461	10.61	17
18	Housekeepers	15,229	15,245	135,901	8.91	18
19	Laundry	6,421	6,437	47,363	7.36	19
20	Administrator	2,080	2,080	75,345	36.22	20
21	Assistant Administrator	2,080	2,080	17,632	8.48	21
22	Other Administrative					22
23	Office Manager	3,891	3,953	38,375	9.71	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,268	2,284	28,201	12.35	31
32	Other Health C: Care Plan Coord	5,864	5,978	83,056	13.89	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,751	193,852	$ 2,376,985 *	$ 12.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	7,500	9,3	36
37	Medical Records Consultant	1 visit	123	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,860	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 10,483		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	25	$ 1,244	10,3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	25	$ 1,244		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Swift	Ass Aadmin	0	$ 17,632
Tony Twardowski	Admin	0	75,345
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,977

B. Administrative - Other

Description	Amount
Management Fee Expense (eliminated in Col. 7)	$ 122,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 122,500

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser,	Accounting	$ 1,600
Computer Services	Computer Services	2,625
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,225

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,600
Unemployment Compensation Insurance	139,336
FICA Taxes	178,150
Employee Health Insurance	5,823
Employee Meals	3,905
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	9,836
TOTAL (agree to Schedule V, line 22, col.8)	$ 395,650

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,763
Advertising: Employee Recruitment	6,130
Health Care Worker Background Check (Indicate # of checks performed 495)	
Patient Background Checks	4,952
Misc Dues & Subscriptions	222
Home Office Allocation	2,262
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,329

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	890
Home Office Allocation	1,695
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,585

* Attach copy of IMRF notifications

**See instructions.

Petersen Health Care, Inc. (Timbercreek)
Provider Number - 0047522
FYE: 12/31/2006 Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		4,225
Allocated from Home Office		
Other Professional Fees	13,988	
Legal	188	
Other Professional Fees - PHO	5,760	
Legal - PHO	177	
		20,113
Total (agree to Schedule V, line 19, column 8)		24,338

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7								N/A					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **N**

(2) Are there any dues to nursing home associations included on the cost report? **N**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **N** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **N** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Y**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,819** Line **10A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Y** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **N/A**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **110,595**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **N** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Y**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,905** Has any meal income been offset against related costs? **Y** Indicate the amount. $ **3,880**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **N**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Y**
Firm Name: **Ginoli & Co.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Y**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees